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DIPSOMANIA

AND ITS

TREATMENT BY SUGGESTION

BY

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ALTHOUGH I intend to refer to dipsomania alone, I do not wish it to be supposed that this is the only form of intemperance which can be cured by suggestion. I have chosen this class for the simple reason that nearly all my inebriate patients have belonged to it.

First, a word as to dipsomania itself, and the distinctions between it and ordinary alcoholism. A typical case of the former presents the following phenomena:—The patient, during a period of total abstinence, begins to be haunted with ideas about drink. This is soon followed by the desire to drink. At first this impulse is strenuously combatted by the will; it then becomes irresistable, as the torture of the craving is so great that the patient feels it must be gratified at any cost. Even yet his will and conscience have not ceased to struggle, and he determines to satisfy the craving with the least amount of alcohol possible, and not give way to a drunken bout. As soon, however, as the first glass is taken the craving is increased instead of diminished, and the will, in despair, now abandons the struggle it feels itself incapable of carrying on successfully. The patient drinks in excess for a period varying from a day to a week or more; then the craving suddenly disappears. This stage is followed by one of physical illness, accompanied

by much mental anguish and remorse. These conditions in their turn disappear, and the patient enjoys a period of more or less complete health and comfort, undisturbed by any morbid craving for stimulants. This passes, and a new attack begins which follows the course of its predecessors.

The exciting causes of dipsomania.—In many, but by no means in all my cases, there was a family history of alcoholism. It is difficult to determine what part this played in the production of the dipsomania, as I have also known many instances where drunkenness in the parents was followed by total abstinence in the children. On the other hand, all the dipsomaniacs I have observed have shown one or more symptoms of degeneracy; the majority of them have been impulsive, nervous, emotional, sensitive and thus more or less ill-balanced mentally. All conditions in the parents likely to produce degeneracy in the children may, therefore, be regarded as possible exciting causes of dipsomania.

An accidental circumstance—usually some mental trouble—is generally the immediate exciting cause of the first attack. Similar causes may excite subsequent ones, but, when the disease is fully developed, its manifestations occur at more or less regular intervals and often without any discoverable immediate exciting cause. I do not know, however, of a single case in which dipsomania has been suddenly aroused—no matter by what cause—in those who till then had been total abstainers. In all there was a previous history of the use of alcohol. Sometimes this had been taken moderately for years, and then illness or trouble had, apparently, excited the dipsomania. At others, the patients had both enjoyed and abused alcohol, at first taking it in moderate quantities regularly with occasional excesses, then losing both pleasure and control and developing in their stead the symptoms of dipsomania. One of my patients tells me she cannot remember when she did not take stimulants. Even when quite a little girl she had her miniature tankard of beer at meals and her glass of port at dessert. After a time dipsomania appeared, and if she took stimulants at all she drank until intoxication ensued.

Differences between dipsomania and other forms of intemperance.—The conditions essentially characteristic of dipsomania are not found amongst the majority of those who use alcohol in excess. There are, it is true, many degenerates amongst the ranks of

the latter, but here degeneracy is not, as in dipsomania, the essential factor in the case. Many persons, who are strong both mentally and physically, habitually take too much alcohol —they do so on account of the physical comfort or mental pleasure it brings. Usually they do not struggle against their self-indulgence until they can no longer keep it within bounds, and it begins to endanger their health, pocket, or reputation. The dipsomaniac, on the other hand, drinks because he is impelled to do so against his will, and may be compared to the man who dreads falling over a precipice and yet feels irresistably tempted to throw himself into the gulf below. Drink, though it may have been enjoyed previously, now gives him neither physical comfort nor mental pleasure, and he struggles through his attack like a felon working out his sentence.

The *moral condition* of the ordinary inebriate differs widely from that of the dipsomaniac. Shame is often sadly lacking in the former, and some even boast of the amount of alcohol they have consumed and the number of drunken bouts they have indulged in. The dipsomaniac, on the contrary, feels his degradation keenly; his attacks cause him intense mental anguish and he often does everything in his power to conceal them from others. Thus, some of my female patients, when the craving could no longer be resisted, secreted bottles of spirits in their bedrooms and got their attack over by a night of drinking—repeating this periodically for years without being found out. One man invariably left his home in the West End as soon as an attack came on and, until it was over, remained in suburbs where there was no likelihood of his being recognised. During the day he drank first in one public-house, then in another, speaking to no one, and at night found a bed in the neighbourhood. This went on for about a week; then the attack terminated and he returned home ill and miserable. If his money gave out, instead of going home for more, he pawned his watch or other valuables.

Further, the drunken bouts of the dipsomaniac, unlike those of the ordinary inebriate, are rarely associated with other excesses. Finally, when the alcoholic develops symptoms of physical and mental deterioration, this comes as the result of his drinking. In the dipsomaniac, on the contrary, the morbid changes which characterise the state existed before drinking took place and actually were the cause of its happening.

The following are successful cases drawn from my own practice :—

(1). Mr. A., aged 33, April 30, 1890. Father and mother strictly temperate, but at least one of his uncles drank and a cousin died in an asylum from drink. One of his brothers, who drank to excess and had been in an asylum, committed suicide at the age of 37. The patient began to take stimulants at 17, when at Edinburgh University, drank heavily without apparent bad effect until 19, then had a severe attack of typhoid fever. At 20 he left the University, went into business, and continued drinking until he was 24. He then abstained for a year, after which he commenced to have periodic breakdowns more and more closely resembling genuine dipsomania. In 1884, his friends induced him to separate from his wife and to place himself under control—this was repeated twice without good result. Finally, in 1887, he entered a retreat for a year, but soon after leaving began to have well marked attacks of dipsomania. There was usually a week's abstinence, then two or three days of constant drinking, followed by abstinence and drinking again in their turn. On several occasions he accidentally injured his head severely ; in the spring of 1887, he began to have attacks of hemicrania, the pain becoming permanent before the end of the year. The hemicrania had been treated without success by the extraction of all bad teeth and the internal administration of croton chloral, ammonium bromide, phosphorus, strychnine, &c. When the patient started business he possessed a considerable private fortune, but by this time it was entirely dissipated. The above history was confirmed by Dr. A., the patient's brother.

I found Mr. A. emaciated, nervous and feeble. He complained greatly of hemicrania and insomnia and there was marked muscular tremor. I hypnotised him from April 30 to May 17, 1890. At the end of the first week the hemicrania and insomnia had disappeared, and, during the latter half of the treatment, he neither took alcohol nor had any craving for it. He left me on May 17, but relapsed a month later and returned for further treatment. He was hypnotised daily for a week and a much deeper stage induced. On December 31, 1890, he wrote to say that he had never touched stimulants since leaving me; had neither hemicrania nor insomnia and was working from ten to twelve hours daily. This report was confirmed from time to

time by letters from other relatives. Thus, Dr. A. wrote, "I feel that I cannot sufficiently thank you or congratulate you on the result in my brother's case. It is to me very wonderful."

I did not see Mr. A. again until July 18, 1893, when he consulted me on account of insomnia resulting from business worries. He was easily hypnotised and the insomnia at once disappeared. From this date I have seen Mr. A. occasionally. He is still an abstainer, is working hard and bringing up his family well. When I last saw him, he told me was going to send his eldest son to Edinburgh to study medicine.

(2). Dr. B., aged 32, February 1, 1893. Commenced taking stimulants when at college and continued to do so regularly afterwards, but rarely to excess till about five years ago. At that time he had been in practice for two years, and had done well until he began to have periodical drinking bouts. In order to restrain him, one or other of his relatives always lived with him, and everything was done to prevent stimulants being introduced into the house. Despite this, he drank rectified spirits in secret, sometimes several gallons a month. His health suffered greatly; he was frequently on the verge of delirium tremens and on one occasion was supposed to have had slight cerebral hæmorrhage. He complained greatly of palpitation and of angina pectoris, and asserted it was the pain of the latter which drove him to take stimulants. His drinking bouts became more and more frequent, and he was compelled to abandon work and return home. Under careful supervision he became much steadier, and his parents purchased another practice for him. Here the former history was repeated; not only did he drink heavily, but he also took large doses of narcotics. His parents informed me that, if I failed to cure him, they would be compelled to keep him at home, and to give up all idea of his being able to follow his profession.

I hypnotised Dr. B. 44 times, from February 21 to April 18, 1893. From the first day I saw him he entirely refrained from stimulants and narcotics, and all craving for them rapidly disappeared. He quickly improved in health and weight, and ceased to complain of palpitation or angina. At the conclusion of the treatment he returned to work, and, after passing twelve months without relapse, married. On February 27, 1894 his mother wrote as follows:—"Your treatment has been completely successful. My son is perfectly well and quite like his old

self—sound in mind and body—and without the slightest desire or need to take stimulants or drugs in any form whatever. His practice increases steadily. Could anything be more satisfactory?"

About the same date Dr. B. wrote saying:—"I have never felt better in my life. I have not the least inclination to take stimulants, and have lost all my attacks of palpitation from which I had suffered during the last fourteen years." Since then I have heard once or twice a year either from my patient or his wife. All the reports are of the same character—he is well, strong, happy and a continued total abstainer.

(3). Mrs. C., aged 44, November 23, 1894. Family history of alcoholism. At the age of 20 the patient began to have frequent hysterical attacks, and for these stimulants were prescribed in rather large quantities. Two years later she began to take stimulants in excess, but did not do so frequently and rarely became intoxicated. From 32 to 36 she was an abstainer; then commenced taking stimulants again and attacks of genuine dipsomania soon appeared. The patient suffered from an almost constant craving for alcohol. She was, however, a woman of culture, refinement and high principle—devoted to her husband and children—and the idea of giving way to drink was in every way abhorrent to her. She therefore struggled with all her might against the temptation; resisted it successfully for a week or two, then the craving became irresistable and a drinking bout followed I hypnotised Mrs. C. thirty times, from November 23, 1894 to February 14, 1895 From the very beginning of the treatment she abstained from stimulants, but the craving, although much diminished, did not entirely disappear for some months. Up to the present date there has been absolutely no relapse.

I could cite many other successful cases, but regret that I am not at present able to give my statistics as a whole. These I hope to publish later, together with other therapeutic results, in a work on hypnotism I am now writing. Although I have had many failures, few of these have been complete, as, even in the worst cases, there has generally been some temporary remission of the disease. At first I attached little importance to the cases that relapsed. These, however, are not without value—for example, one patient abstained for six months after treatment, then drank as badly as ever. His wife afterwards told me that

those were the only happy months she had spent in her married life, and that she was deeply grateful for them.

Many successful cases are reported by Continental observers, amongst whom may be cited Voisin, Ladame, Forel, Tatzel, Hirt, Neilson, de Jong, Liébeault, Bernheim, van Eeden, van Renterghem, Wetterstrand, Schrenck-Notzing and Krafft-Ebing.

Ladame drew special attention to three cases treated by Forel. All of them had suffered from chronic alcoholism after attacks of delirium tremens, and were inmates of Forel's asylum. They were extremely difficult to manage, and expressed their determination to resume drinking as soon as they were liberated, but, despite this, complete recovery followed hypnotic treatment.

The tendency of dipsomania to recur renders the compilation of accurate statistics extremely difficult, and it is obviously absurd to describe as cured, patients who have stopped drinking for a month or two. On the other hand, when years have passed since treatment, it is not always possible to get reports from patients who live at a distance.

According to Ladame, the prognosis in dipsomania, especially where there is a family history of alcoholism, is an extremely grave one, and prolonged retention in an asylum or a retreat rarely yields good results. Total abstinence societies do good work, but their methods in which suggestion plays an important part—depend largely upon religious influences to which all are not susceptible.

Hypnotic treatment, which he regards as the best, is by no means universally successful. Much depends upon the patient's willingness to be cured, his susceptibility to hypnotic influence and the operator's management of the case. Before discussing these points, I wish to say something as to the phenomena of hypnosis and their theoretical explanation. Of the former the following is a summary:—In hypnosis, the subject loses none of the attributes of his normal condition. Further, he has acquired new and varied powers, and a control over his own mind and body without parallel in waking life. He can alter the rhythm of his pulse, control his secretions and excretions, and increase or arrest the activity of his special senses. He can induce anæsthesia and analgesia, recall memories lost to waking life and obliterate others, and, even when all the phenomena are

elicited by the suggestions of the operator who has hypnotised him, maintain consciousness and volition unimpaired. From the therapeutic side, he can obtain relief from the pain of disease or injury; produce sleep at will and for as long as he likes. He can escape from obsessions and get rid of numerous functional nervous disturbances. Finally, he can be taught to hypnotise himself, and from henceforth—free from all external interference—can by self-suggestion produce phenomena identical with those just described.

Memory is profoundly altered. In the normal state the subject remembers the events of his ordinary life alone; hypnotised, he not only recalls all the events of previous hypnoses, but also those of his ordinary life. This picture refers only to deep hypnosis. In slighter stages there is to be found neither loss of memory, nor any condition resembling sleep or unconsciousness. Notwithstanding this, suggestion can still produce results beyond the power of the waking will. In many instances it is difficult or impossible to prove that the patient has been hypnotised at all. For example, in Mrs C's case, I could only say that she rested quietly while suggestions were made and subsequently recovered from her dipsomania. The therapeutic result was the only evidence of hypnosis, but, as the disease had previously resisted prolonged and varied suggestions in the normal state, it appears probable that the treatment produced some change—whether this may be justly called hypnosis or not—which rendered her susceptible to suggestion. As the point is a doubtful one, I use the word "suggestion" in the title of my lecture, instead of the more limited term "hypnotism."

In discussing hypnotic theories it must first be admitted that hypnotism is in reality mesmerism explained scientifically and freed from erroneous observation. Mesmeric phenomena, which have stood the test of scientific investigation, are now described as hypnotic. Therapeutic results, equal to those observed at Nancy, were formerly obtained by Elliotson at University College Hospital, while the modern employment of hypnotism as an anæsthetic has never rivalled its use by Esdaile, who, under Government supervision in India, from 1846 to 1851, recorded 300 capital operations and many thousand minor ones. In their day, however, the true was intermingled with the false, both as to their alleged facts and their interpretation. Mesmeric phenomena were supposed to be due to a mysterious force or fluid

which existed in the operator and in certain metals, magnets, &c. It was believed that the operator could dominate the will of the subject and mesmerise him from a distance, while instances of clairvoyance and telepathy were regarded as of every-day occurrence. These views were successfully combatted by Braid, who commenced his mesmeric researches in 1841 and continued them till his death in 1860.

The following is a brief summary of his more important observations:—(1) The phenomena, purely subjective in their origin, arose from changes in the nervous system of the subject and were entirely independent of any magnetic force or fluid. (2) Magnets, metals, drugs in sealed tubes, &c., produced nothing except when the subject knew what was expected, or divined it from leading questions. (3) No one could be hypnotised against his will. (4) In all stages the subjects rejected unpleasant suggestions and resisted disagreeable acts, no matter whether the latter were attempted by the operator, or by others. (5) In hypnosis refinement was more marked than in the normal state and the moral sense increased. (6) The essential condition was monoideism and concentration of attention. (7) Hypnotic phenomena might be induced without the subject having passed through any condition resembling sleep. (8) The mentally healthy were the easiest, the hysterical the most difficult, to influence.

Braid substituted the word hypnotism for that of mesmerism and invented the terminology still in use. Later, he proposed the term monoideism instead of hypnotism. The latter, he said, implied the idea of sleep, and only 10 per cent. of the patients he cured passed into a condition which even superficially resembled sleep.

All Braid's later and more valuable work was ignored or forgotten, and many of the errors he successfully combatted have been repeated in the Continental revival of hypnotism. Thus, the Salpêtrière school, with their magnets, metals, drugs in sealed tubes, &c., simply reproduced the mesmeric fallacies Braid exposed. The Nancy school in their earlier days believed, like the mesmerists, that the subject was under the dominion of the operator—they based this theory entirely on experimental crimes. A subject, for example, was told that a lump of sugar was arsenic, and that he was to put it into a friend's teacup. Because he obeyed the suggestion, he was

assumed to be a criminal. I have shown, however, by questioning in subsequent hypnoses, that the subjects invariably knew what they were doing. If they performed some act, which the operator falsely described as hurtful, they knew it involved no wrong, but they always refused to do anything which was repugnant to their moral sense. Now, the members of the Nancy school are abandoning their earlier position and coming more into line with the views of Braid. They still differ from him, however, on one important point. He regarded suggestion as the artifice by means of which the phenomena of hypnosis were excited—these being rendered possible by changes in the nervous system of the subject. They hold that suggestion not only excites the phenomena of hypnosis, but also represents the condition itself. According to Bernheim, there is nothing in hypnotism but the name, *suggestion* is everything.

Neither mental concentration nor suggestion, however, can explain all the phenomena of hypnosis, and the only theory which is at all satisfactory is that of which Frederic Myers is the clearest exponent. According to him, the phenomena of hypnosis are due to the action of an intelligent secondary self, which he terms the *subliminal consciousness*. The alterations of consciousness presented by certain diseased conditions are examples of its morbid action, while its healthy working is not only to be seen in hypnosis, but also in the inspirations of genius. The latter, although supposed to be the production of the normal consciousness, have in reality been first elaborated in the subterranean workshops of the secondary self, and then presented to the primary one as a finished product.

Granting that hypnotism is a powerful agent, which may be applied more or less successfully, and absolutely without danger, to the relief or cure of dipsomania, there still remain several important points for consideration :—

(1). The patient must be willing to be cured. Difficulties as to this are more frequently encountered in cases of chronic alcholism than in dipsomania. Even the latter patients, however, sometimes dread treatment as they fear it may raise an artificial barrier between them and drink, and yet leave them fighting with the craving. As a rule, however, their fears are easily dispelled by means of a little tact and explanation.

(2). Susceptibility to hypnosis is a varying and important factor. Most authorities agree that all, except idiots and those

suffering from certain forms of mental disease, can be hypnotised. On the other hand, time and trouble are often requisite and frequently slight hypnosis alone can be induced. Fortunately, as we have seen, deep hypnosis is not essential to the production of good therapeutic results.

(3). In dipsomania one ought to begin treatment at the commencement of a period of quiesence, and aim at preventing, or at all events, retarding and weakening the next attack. When stimulants are taken continuously the difficulties are greater, but the patient must be helped and encouraged to reduce them as speedily as possible.

(4). The management of the patient during the earlier part of the treatment, before suggestion has taken effect, is important. If possible, he should not be left alone, but always have near him some trustworthy person to whom he can confide his temptations, and turn for aid in overcoming them.

(5). The operator must be persevering and not easily discouraged; many patients, who ultimately do well, relapse more than once during treatment.

(6). A distaste for alcohol ought to be suggested, as well as the abolition of the craving for it. The patient must be made to understand that he can never look forward to being a moderate drinker, and that the only choice before him lies between total abstinence or the gutter.

(7). Even when the craving disappears quickly, the patients ought to be hypnotised regularly for a month. If they can be seen from time to time for the next six months, so much the better and safer.

(8). The object of the treatment is not only to cure the diseased craving, but also to strengthen the will of the patient and help him to combat the temptations of social life. The latter point is important. Some patients forget what they have gone through, and, although they have no diseased craving, yield to ordinary temptation. If the patient has not gained the power of controlling himself, the treatment has failed in its object: for self-control, not artificial restraint, is its essential feature. With many of my patients restraint had been tried without benefit. One had passed three years in a retreat, with only a few weeks freedom from drunkenness between the second and third years. Possibly my patients may have been unfortunate in the Institutions they selected, certainly all complained that—

restraint alone excepted—nothing was done to cure them. Lady Henry Somerset's Institutions, where healthy work and religious influences play an important part, contrast favourably with those just referred to.

In conclusion, although I have found the treatment of dipsomania hard and anxious work, it has also been a pleasure. If the three cases I have cited comprised all my successes, the work would still have been worth doing. A new year, however, never dawns without old patients telling me of their continued abstinence, health and happiness, and wishing me like success in my efforts for others.

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